FORM 1203 (02/15) STATE OF NEW YORK - DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION

# EMPLOYEE ACCIDENT / INJURY REPORT

DELIVER THIS REPORT TO PERSONNEL WITHIN 24 HOURS
(#1 - 14 to be completed by Employee)

Personnel use Only (check one) ☐ Lost Time ☐ No Lost Time

| | | |
|---|---|---|
| 1. Facility | | 2. Date of Accident |
| 3. Time of Accident | 4. Place of Accident | |
| 5. Employee Name | | 6. Title |
| 7. Employee Work Location | 8. Shift | 9. Pass Days |
| 10. Employee remained on duty? Yes ☐ No ☐ | | 11. Employee required medical attention? Yes ☐ No ☐ |

12. Statement of Employee

Note: Secondary Employment: A preexisting authorization for outside employment will be automatically reviewed for any period of time that an employee is on a Limited Duty assignment or absent from work as a result of an illness or injury (see Directive #2218, "Outside Employment").

13. Signature of Employee: _____ 14. Date: _____

15. Name of Eyewitnesses: _____

16. Statement of Supervisor: _____

| 17. Supervisor's Name | 18. Supervisor's Signature | 19. Date |
|---|---|---|
| | | |

## FACILITY HEALTH SERVICES REPORT

20. Evaluation/Findings: _____

21. Services Provided: ☐ First Aid/Assessment ☐ Medical Treatment: _____

22. Personal Physician of Injured Employee: _____ Phone No.: _____

Address: _____

23. Date Injury Reported to Medical Unit: _____ 24. Time: _____

25. Signature: _____ 26. Title: _____

Distribution: White – Personnel Canary – Fire/Safety Officer Pink – Employee